SPECIALTY GUIDELINE MANAGEMENT

AUSTEDO (deutetrabenazine)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
Treatment of chorea associated with Huntington's disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Chorea associated with Huntington disease
Authorization of 12 months may be granted for treatment of chorea associated with Huntington disease.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Austedo [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc. April 2017.